(B) in the case the individual is not described in subparagraph (A) and not enrolled in a Federal health care program, the individual.

(July 1, 1944, ch. 373, title XXVII, § 2799B–6, as added Pub. L. 116–260, div. BB, title I, § 112, Dec. 27, 2020, 134 Stat. 2866.)

§ 300gg–137. Patient-provider dispute resolution

(a) In general

Not later than January 1, 2022, the Secretary shall establish a process (in this subsection referred to as the ''patient-provider dispute resolution process'') under which an uninsured individual, with respect to an item or service, who received, pursuant to section 300gg–136 of this title, from a health care provider or health care facility a good-faith estimate of the expected charges for furnishing such item or service to such individual and who after being furnished such item or service by such provider or facility is billed by such provider or facility for such item or service for charges that are substantially in excess of such estimate, may seek a determination from a selected dispute resolution entity for the charges to be paid by such individual (in lieu of such amount so billed) to such provider or facility for such item or service. For purposes of this subsection, the term ''uninsured individual'' means, with respect to an item or service, an individual who does not have benefits for such item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, Federal health care program (as defined in section 1320a–7b(f) of this title), or a health benefits plan under chapter 89 of title 5 (or an individual who has benefits for such item or service under a group health plan or individual or group health insurance coverage offered by a health insurance issuer, but who does not seek to have a claim for such item or service submitted to such plan or coverage).

(b) Selection of entities

Under the patient-provider dispute resolution process, the Secretary shall, with respect to a determination sought by an individual under subsection (a), with respect to charges to be paid by such individual to a health care provider or health care facility described in such paragraph for an item or service furnished to such individual by such provider or facility, provide for—

(1) a method to select to make such determination an entity certified under subsection (d) that—

(A) is not a party to such determination or an employee or agent of such party;

(B) does not have a material familial, financial, or professional relationship with such a party; and

(C) does not otherwise have a conflict of interest with such a party (as determined by the Secretary); and

(2) the provision of a notification of such selection to the individual and the provider or facility (as applicable) party to such determination.

An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the ''selected dispute resolution entity'' with respect to such determination.

(c) Administrative fee

The Secretary shall establish a fee to participate in the patient-provider dispute resolution process in such a manner as to not create a barrier to an uninsured individual's access to such process.

(d) Certification

The Secretary shall establish or recognize a process to certify entities under this subparagraph.[1] Such process shall ensure that an entity so certified satisfies at least the criteria specified in section 300gg–111(c) of this title.

(July 1, 1944, ch. 373, title XXVII, § 2799B–7, as added Pub. L. 116–260, div. BB, title I, § 112, Dec. 27, 2020, 134 Stat. 2867.)

§ 300gg–138. Continuity of care

A health care provider or health care facility shall, in the case of an individual furnished items and services by such provider or facility for which coverage is provided under a group health plan or group or individual health insurance coverage pursuant to section 300gg–113 of this title, section 9818 of title 26, or section 1185g of title 29—

(1) accept payment from such plan or such issuer (as applicable) (and cost-sharing from such individual, if applicable, in accordance with subsection (a)(2)(C) of such section 300gg–113 of this title, 9818 of title 26, or 1185g of title 29) for such items and services as payment in full for such items and services; and

(2) continue to adhere to all policies, procedures, and quality standards imposed by such plan or issuer with respect to such individual and such items and services in the same manner as if such termination had not occurred.

(July 1, 1944, ch. 373, title XXVII, § 2799B–8, as added Pub. L. 116–260, div. BB, title I, § 113(d), Dec. 27, 2020, 134 Stat. 2873.)

§ 300gg–139. Provider requirements to protect patients and improve the accuracy of provider directory information

(a) Provider business processes

Beginning not later than January 1, 2022, each health care provider and each health care facility shall have in place business processes to ensure the timely provision of provider directory information to a group health plan or a health insurance issuer offering group or individual health insurance coverage to support compliance by such plans or issuers with section 300gg–115(a)(1) of this title, section 1185i(a)(1) of title 29, or section 9820(a)(1) of title 26, as applicable. Such providers shall submit provider directory information to a plan or issuers, at a minimum—

(1) when the provider or facility begins a network agreement with a plan or with an issuer with respect to certain coverage;

(2) when the provider or facility terminates a network agreement with a plan or with an issuer with respect to certain coverage;

[1] So in original.